in those people who are ultra-rapid metabolisers due to the CYP2D6 duplication. Mothers and babies should be carefully observed and monitored for signs of opioid toxicity. In most cases the occurrence of central nervous system depression with opioids is consistent between mother and baby (although babies appear to be more sensitive to the effects of opioids) and so if a mother appears to have adverse effects of opioids there should be a low threshold for examining the baby and excluding toxicity.[12] If longer-term pain relief is required, then other drugs such as NSAIDs should be considered as first-line treatment.

Conclusion and recommendations

At MotherSafe we reassure women regarding inadvertent NSAID use, but recommend paracetamol as first-line treatment of fever and pain during pregnancy. Codeine or another opioid analgesic can be added to treat more severe pain. NSAID use is contraindicated in the third trimester and alternative analgesics should also be considered in the first trimester.

Women and their doctors should however be reassured that there are safe options to treat pain, both acute and chronic, during pregnancy and breastfeeding.

References

1. Henry A, Crowther C. Patterns of medication use during and prior to pregnancy: the MAP study. Aust N Z J Obstet Gynaecol 2000;40:165-72.
2. Rebordosa C, Kogevinas M, Horvath-Puho E, Norgard B, Morales M, Czeizel AE, et al. Acetaminophen use during pregnancy: effects on risk for congenital abnormalities. Am J Obstet Gynecol 2008;198:178. e1-7.
3. Erkan D, Patel S, Nuzzo M, Gerosa M, Meroni PL, Tincani A, et al. Management of the controversial aspects of the antiphospholipid syndrome pregnancies: a guide for clinicians and researchers. Rheumatology (Oxford) 2008;47 Suppl 3:iii23-7.
4. Kozer E, Nikfar S, Costei A, Boskovic R, Nulman I, Koren G. Aspirin consumption during the first trimester of pregnancy and congenital anomalies: a meta-analysis. Am J Obstet Gynecol 2002;187:1623-30.
5. Nielsen GL, Sorensen HT, Larsen H, Pedersen L. Risk of adverse birth outcome and miscarriage in pregnant users of non-steroidal anti-inflammatory drugs: population based observational study and case-control study. BMJ 2001;322:266-70.
6. Li DK, Liu L, Odouli R. Exposure to non-steroidal anti-inflammatory drugs during pregnancy and risk of miscarriage: population based cohort study. BMJ 2003;327:368.
7. Gloor JM, Muchant DG, Norling LL. Prenatal maternal indomethacin use resulting in prolonged neonatal renal insufficiency. J Perinatol 1993;13:425-7.
8. van der Heijden BJ, Carlus C, Narcy F, Bavoux F, Delezoide AL, Gubler MC. Persistent anuria, neonatal death, and renal microcystic lesions after prenatal exposure to indomethacin. Am J Obstet Gynecol 1994;171:617-23.
9. Nulman I, Rovet J, Stewart DE, Wolpin J, Pace-Asciak P, Shuhaiber S, et al. Child development following exposure to tricyclic antidepressants or fluoxetine throughout fetal life: a prospective, controlled study. Am J Psychiatry 2002;159:1889-95.
10. Hale TW. Medications and mothers' milk. 14th ed. Amarillo (TX): Hale Publishing; 2010.
11. Koren G, Cairns J, Chitayat D, Gaedigk A, Leeder SJ. Pharmacogenetics of morphine poisoning in a breastfed neonate of a codeine-prescribed mother. Lancet 2006;368:704.
12. Madadi P, Moretti M, Djokanovic N, Bozzo P, Nulman I, Ito S, et al. Guidelines for maternal codeine use during breastfeeding. Can Fam Physician 2009;55:1077-8.

Conflict of interest: none declared

Self-test questions

The following statements are either true or false (answers on page 31)

3. Paracetamol does not cross the placenta.
4. NSAIDs should be avoided during the third trimester.

Dental notes

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Analgesics and pain relief in pregnancy and breastfeeding

Dentists often advise patients regarding pain management for dental pain and generally the recommendation for pregnant women to use paracetamol, as the first-line treatment of fever and pain, is reasonable. However, on occasions the dental pain experienced will warrant the short-term use of drugs which include therapeutic doses of codeine. The use of these drugs for short-term treatment (2–3 days) in women who are pregnant or breastfeeding should not pose any adverse risk.

It is probably prudent for dentists not to prescribe non-steroidal anti-inflammatory drugs for pain relief during pregnancy. If their patients are experiencing profound, persistent pain it would be advisable to liaise with the patient's medical practitioner for appropriate management. Importantly, accurate diagnosis and timely dental treatment will dramatically and effectively reduce the pain for these patients. This will diminish the requirement for systemic pain relief.